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## **Consequences of activation to work targeting young people with health related problems**

*a comparison of activation policies in Sweden and Denmark*

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## Consequences of activation to work targeting young people with health related problems - a comparison of activation policies in Sweden and Denmark

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### Introduction

The Nordic countries have had a long history of an active labour market policy. Over the years activation in different forms have been used as a method to combat unemployment amongst the unemployed where the only problem is the lack of a job itself. However activation policy is now permeating policy within the field of social and economic protection for adults who for medical reasons cannot work. A strong emphasis on paid work as the main source to social inclusion has legitimized work promoting activation targeting socially vulnerable groups such as adults with comprehensive health problems. This group previously had been considered unable to take up ordinary work (Junestav 2007, Nørup, 2014; Wright, 2011; Breidahl, 2011; Van Berkel & Valkenburg, 2007). Nevertheless little knowledge exists of the effects and consequences of activation to work targeting especially young adults with medical problems.

During the last two centuries, the Nordic countries – as with many other Western countries – have introduced active welfare state reforms including what internationally has been labelled active social policy, activation, work-first and work-fare (Lødemel and Trickey 2001; Brodtkin and Larsen 2013; Larsen et al. 2001). Contrary to the idea of unconditional benefit support, the active approach entails reforms of income protection schemes and the introduction of activation and reintegration programs. The rationale behind these reforms is: - to combat welfare dependency partly by making income protection schemes more conditional on the attitudes and behavior of benefit recipients, partly by offering activation and reintegration services to improve the employability of the benefit recipients. Scholars have talked of “a policy of conditionality” (Swärd & Egerö, 2008; Baadsgaard et al, 2012; Clement, 2004).

When looking at the activation policies targeting young people with health related problems the political argument has often been concerned with labour market inclusion as the key to social

inclusion (Nørup, 2014; Bothfeld & Betzelt, 2011; Nørup m.fl., 2014; Baadsgaard m.fl., 2014; Jørgensen, 2010). This argument represents a shift in the understanding of social inclusion that has gradually manifested itself over the past two decades. The definition of social inclusion has been narrowed and is now primarily a question of being included in the labour market and participating in paid work (Baadsgaard et al, 2014, Nørup et al, 2014; Nørup, 2014; Andersen & Larsen, 2011; Born & Jensen, 2005). On the one hand a still increasingly strong focus on activation is adopted. On the other hand, the meaning of activity is reduced so that only paid work is considered as an including activity (Hultqvist, 2014; Nørup, 2014). With young people with severe health problem as a target group, the narrowed definition of social inclusion has served as a political argument as well as a legitimization of extensive activation to work programs.

This change is by no means unproblematic. Based on recent empirical analysis from Sweden and Denmark we argue that the strong emphasis on work has counterproductive consequences when directed towards individuals whose problems are medical rather than related to their position in the labour market. We also argue that it constitutes a significant shift in the relation between the state and the individual. With these statements as a common starting point we elaborate on the different shapes activation policy takes in the Swedish activity compensation (aktivitetsersättning) and the Danish resource activation (ressourceforløb), and how it affects the young individuals it is targeting.

### **Two comparable social policy programs with respective differences**

Despite the overall similarities between the welfare systems in the Nordic countries, there are important differences between the degrees to which this policy change has taken place. The extent of the activation to work and the degree to which the strong workfare elements have been implemented and adopted in frontline practices vary. Even though there are some overall similarities between the Nordic countries some key differences in the way the activation policy is implemented and how it is translated from policy to frontline practice are found. This paper investigates the Swedish and the Danish activation policies targeting young adults, who for medical reasons are unable to take up work.

As with the other Nordic countries, Sweden and Denmark have a social group of young adults who are excluded from or never enter the labour market due to medical problems, diagnosed as physical as well as mental or cognitive problems. In both countries only a small proportion<sup>1</sup> of the long term unemployed are young adults (OECD, 2010; Jobindsats.dk; Eurostat.eu). A large percentage of

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<sup>1</sup> The exact percentage varies between around 4 % up to around 10 % depending on method of a calculation.

these young adults is probably excluded from the labour market because of severe health problems, and in many cases these are also combined with social problems (Dalgaard, 2011; DISCUS, 2008). In both countries the importance of integrating these young adults in to the labour market has been strongly emphasized by politicians and governments as well as local and national labour market authorities.

Reforms of the activation policies targeting these young adults have been realized in Sweden as well as in Denmark in an attempt to reduce the number of young people, who are excluded from the labour market. In both countries the strategy has been to close the possibility to be granted permanent benefit compensation for young adults with a longstanding medically-caused incapacity for work, i.e., disability pension.<sup>2</sup> Disability pension has in both countries been replaced by activation policies striving to rehabilitate these young adults into the labour market. In both cases a strong emphasis has been put on the importance of paid work as a key factor to social inclusion and as one of the most important elements of being an active citizen contributing to the society. Thus, there are some striking similarities between the two countries when looking at the overall picture.

However, when studying the policies and practices more closely some crucial differences emerge. Even though both Sweden and Denmark have adopted the workfare logic in general, the countries differ, when looking at the degree and strength of the workfare elements that are implemented in practice. As we will discuss later on, we argue that in the Danish case a very strong workfare logic is present in the activation policies with a strong focus on (primarily) economic incentives to work and an emphasis on the duty to take up work over the right to benefits and support from the state. Though the workfare logic is clearly present also in the Swedish case, the activation policies have a softer form with a stronger focus on rights and entitlements, compared to Denmark. The same differences can also be found, when looking at the way the activation policies are implemented in the frontline and when the translation from policy to practice in the frontline takes place (Caswell & Høybye-Mortensen, 2015; Baadsgaard et al, 2014; Hultqvist, 2014; Baadsgaard et al, 2012,). We suggest, in accordance with previous research, that the way of implementing activation policy, can be defined as being 'sharp' and state-focused in the Danish case while in the Swedish case the definition would rather be 'subtle' and individual-focused activation policy. We will elaborate

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<sup>2</sup> Unlike in Sweden, in Denmark it is still possible for young adults to be granted disability pension, but this is in reality only an option for young adults with disabilities such as mentally retardation, severe brain damage and such, where it is very obvious, that they cannot neither care for themselves nor participate in work.

further on this later on in the paper, but first we will give a brief introduction to the Swedish and Danish activation policies targeting young adults with medical problems.

All the five Nordic countries<sup>3</sup> have gradually implemented a workfare orientation in the area of social policy. Amongst the Nordic countries Denmark is probably the country that has implemented workfare policies in the most pure form. In general, the Danish activation policies have been dominated by a high level of control implemented by having standardized availability control of the unemployed or sick person, use of economic sanctions and by making benefits conditional on participation in activation and on work attitude and job searching behavior. 30 years ago these rationales and policies only applied for unemployed with no problems besides not having a job, but over the years the target group for this type of activation has expanded so that the activation policies and the rationales behind now also apply to people receiving sickness benefits and unemployed with extensive problems beside unemployment. The overall pattern is the same in Sweden. What distinguishes workfare policies in Sweden in comparison with those in Denmark is that traditionally the features mentioned above have been directed towards unemployed people. People with medically caused incapacity for work have not been a target group for workfare policies. Taking the program under study here – activity compensation – as an example, participation in activities is a right and not a duty.

### *Resource Activation – the sharp version*

In 2013 the activation to work target group was expanded when a reform of the disability pension and supported labour to people with disabilities (Flexijob) schemes were launched. Politically this reform was introduced not only as an employment policy but as a policy aimed to improve the precarious social situation chronical ill and disabled persons faced due to their health related limitations. The goal was to help them back in ordinary employment.

The reform introduced a strong employment focus directed to chronical ill and disabled persons who previously had not been part of the employment effort due to their extensive impairments. In the program the individual's resources were to be activated in order to facilitate return to work. The reform strongly limited the access to disability pension especially for people under the age of 40 years old, and it expanded the definition of flexijobs, so that the arrangement could be used for

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3 Denmark, Finland, Norway, Iceland and Sweden constitute the Nordic countries.

people with extremely limited ability to work. In practice a flexijob can be granted to people with the ability to work as little as 1-2 hours a week and less than 30 minutes a day<sup>4</sup>.

Instead of qualifying for disability pension the young adults with extensive medical problems are now referred to a special activation scheme, so called resource activation (Ressourceforløb). Resource activation is only targeting people with rather severe medical problems who previously would have been eligible for disability pension. Resource activation is typically granted for a period of two to five years. One intention behind the program was to rehabilitate and (re-)integrate young adults with medical problems on the labour market by improving their employability. Legally the resource activation falls under the jurisdiction of the ministry of employment. Thus resource activation is a part of the employment policy and the local jobcenter is the authority in charge of the activation and also the one who pays for whatever type of treatment or activation the client is given. Despite taking a variety of social and health related factors into account, when the individual resource activation is planned the aim is still rather narrow on employment and only activities that are expected to bring the client closer to the labour market are selected.

For many young adults the resource activation implies a reduction of benefits and a reduction of pay given to people in flexijobs. The benefit given when being part of resource activation is based on the type of benefit, the young adults were entitled to prior to entering the resource activation. Most of these young adults were receiving the lowest level of social assistance (kontanthjælp) before entering the resource activation program. When they enter the program they are given a resource activation benefit, but the level of this benefit is the same as the social benefits they received previously and is substantially lower than the disability pension. Some of the participants would have been entitled to unemployment insurance or sickness benefits prior to entering resource activation which are substantially higher than the social assistance. Even so, since the entitlement to unemployment insurance and sickness benefits require having participated in ordinary employment for a certain period of time before getting ill or unemployed most of the young adults are not entitled to these types of benefits. In practice, most young adults in question do not qualify for more than the absolute minimum of benefit.

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<sup>4</sup> There have recently been examples of flexijobs being granted to persons who were only able to work 13-15 minutes a day.

### *Activity compensation – the soft version*

In 2003, activity compensation (aktivitetsersättning) replaced early retirement pension as a system against financial poverty for persons aged 19 to 29 years and medically diagnosed with a protracted, occupational disability. The reform meant that a specific system for young adults was established, in which a citizenship-based right to participate in a qualified activity was included. Activity was not specified but was meant to be the result of an activity plan set up by the administrator at the local social insurance center and the young adult. The reform explicitly stated that the young should be influential when setting up this plan of activities.

Legally, the system was moved away from the pension system and placed among the sick benefits. This change was partly made in order to politically signal that this program from now on was considered a temporary, not a permanent, benefit. The aim for young adults entitled activity compensation was rather temporary financial security than permanent financial security and the overall goal was for them to return to work.

From the time of implementation, permanent benefit compensation was unavailable for the young adults in question. First, their compensation eligibility was to be re-assessed after no more than three years. Second, no one older than 30 years old could be granted activity compensation. Turning 30 symbolizes the ulterior limit for young adults with activity compensation. The program targeting persons aged between 30 and 65 comprises stricter inclusion criteria.

Contrary to the political ambition to decrease the numbers of young adults who for medical reasons cannot work, the numbers have increased since the reform was launched. The activation element consisting in the right to take part in an activity has not resulted in return to work to the extent that the politicians wished, even though many disabled young adults appreciate having the opportunity to take a course or doing exercise. That it is no longer possible to get permanent benefit compensation also means that theoretically no one is permanently precluded from the labour market. Even for persons with severe disability the goal is to earn a living on paid work.

In the reform of 2003, activity compensation was constructed as a benefit that could only be granted with a time limit and it was no longer a part of the pension system. Nevertheless, the program remains included in the social insurances. Seen as an financial security net for the citizen, this is an important feature. Firstly, utilizing insurance benefits to maintain livelihood is free from social stigma as is the case with social assistance. Theoretically, there is a difference between universal and selective programs. Scholars have talked of one security net for the "worthy" and another for

the "unworthy" in order to describe the status attached to social insurance respectively social assistance (Drugge, 2007; Hollertz, 2010; Jeene, Oorschot & Uunk, 2011; Tussing, 1974). Secondly, activity compensation entitles you to a larger amount of money than does social assistance.

### **Understanding the relationship between citizen and the state - the theoretical framework**

This paper focuses on the consequences of activation to work policies when these policies are targeting young adults with medical problems. In a broader sense the paper highlights what happens to the relationship between individual and state when employment policies permeate the field of social policy targeting vulnerable citizens. It also addresses what consequences this change has for the individual, in this case the young adults eligible for participation in activation compensation or resource activation.

To explain these changes a combination of two theoretical perspectives are applied. Firstly we use Lipsky's distinction between individual focused goals and goals focusing on the state (social engineering) (Lipsky, 2010). These two of goals represent two opposing goals types that often are embedded in public policies. Goals focusing on the individual aim to improve the situation of the individual such as improving life quality, providing af income etc. while state-centered goals aim at fulfilling the interest of the state, for instance reducing expenditures used on benefits, promoting work etc. For instance – in Scandinavian prisons the ambition to avoid isolation and prepare the inmates for a life civilian life after prison stands in contrast to goal of protecting civil society and the general sense of establishing justice. Here the first goal is clearly focused on the individual while the second is strongly state-centered. The two goals are opposing and cannot be met at the same time (Lipsky, 2010). As we argue later in the paper the activation compensation in Sweden and the resource activation in Denmark to different degrees represent the shifting policy goals in the field of social protection of adults who for medical reasons cannot work. To explain the negative social consequences of the workfare logic we draw on the theoretical perspective of Bothfeld and Betzelt (2011, 2013). Crucial to understand and measure the individual life situation and wellbeing is the notion of autonomy, which is the capacity of individuals to reflect on who they want to be and what they like to do (Bothfeld & Bezelt, 2013). This means that social exclusion is caused by a lack of personal autonomy (Ben-Ishai, 2012, 2006) in three different dimensions; the individual, the social and the political dimension (Bothfeld & Betzel, 2011). The individual dimension concerns the individual's sense of belonging and inclusion in society, while the social dimension concerns the social status of the individual and the formal and informal social relations the individual takes



part in. The political dimension concerns the individual's participation in society and the individual's commitment and obligation towards society (Bothfeld & Betzelt, 2011, 2013).

It is important to stress that autonomy is not necessarily incompatible with economic dependence, though some degree of discretion in terms of disposal over money is closely linked to autonomy in a capitalist society. Even more important – to foster autonomy, policies should not prescribe any specific behavior but recognize diverse needs and expectations. Consequently, autonomy-fostering policies rather loosen than strengthen the tie between labour market participation and social provision. (Bothfeld & Betzelt, 2011)

### **Workfare logic targeting people with work disability: Empirical results from two countries**

#### *Resource Activation – a sharp version of workfare*

The Danish study (Nørup, 2014) takes its point of departure in the recent reform of the Danish disability pension and flexijob schemes. The reform has introduced strong employment focus targeting chronically ill and disabled persons. One of the main political arguments for introducing a strong employment focus on this group of severely ill and disabled persons were, that an exclusion from the labour market would cause general social exclusion as well as it would worsen the already precarious social situation ill and disabled persons faced due to their health related limitations.

The study investigates the social consequences of being excluded from the labour market and receiving either temporary benefit compensation (social assistance, sickness benefit etc.) or permanent benefit compensation (disability pensions). The study is quantitative and based on a large set of quantitative data consisting of a survey of approximately 25.000 respondents conducted in the Region of Northern Jutland. The survey is linked to the Danish Registers as well as the DREAM database that measures week for week whether the respondent has received any type of benefits. The register measures week for week throughout the year any public benefits the individual might have received such as unemployment benefits, social assistance or disability pension.

To measure the complex relationship between market exclusion, chronically illness and disability and the experience of social exclusion advanced models of causality have been constructed using structural equation modeling and taking the effects of various factors such as income, education, marital status in to account.

The study finds that young adults with medical problems are more vulnerable to social exclusion than older with similar problems. The reason is probably that the consequences of medical issues that appears later in life when you are married, have finished education, have a strong social network etc. do not influence as negatively as medical issues that are present at the time in your life when your identity is still in formation. The study also concludes that adults with severe medical problems are in a precarious social position because of their medical problems. Because of their medical problems they are also highly likely to get excluded from the labour market, but the vulnerable social situation is *not* caused by their lack of participation in paid work.

In fact young adults with the most serious medical problems experience more extensive negative social and mental consequences when forced to participate in paid work. Moreover, participation in paid work does not remove or lessen the social exclusion caused by poor health. This is quite contrary the political argument used to legitimize the reform of the recent disability pension scheme.

A central cause for social exclusion found in the study is a lack of autonomy. The results clearly shows that feeling of autonomy and having control and a say in one's own life is crucial to mental and social wellbeing and social participation. The experience of having a "life project" that is not accepted or respected has the opposite effect. Thus results in the study are much line with Bothfeld and Bezelt (2011, 2013).

The Danish frontline workers have to a large extent adapted to and accepted the work fare logic (Nørup et al, 2014; Baadsgaard et al, 2014; Baadsgaard et al, 2012). Danish social workers working with young adults who cannot work have transformed from being social workers acting in the interest of the client to administrators of the policy and acting in the interest of the organization (Nørup et al, 2014, Baadsgaard et al, 2014). In the Danish case the focus of the frontline workers has changed from focusing individual centered goals such as preventing economic poverty and enhancing quality of life by addressing social problems to focusing on state centered goals such reducing expenses to benefits and strongly promoting work. Social issues are not addressed unless they are a part of a strategy to increase the employability (Nørup et al, 2014, Baadsgaard et al, 2014; Baadsgaard et al, 2012).

This also means that the use of force and sanctions to take up work or enter the education system is to a rather large extent accepted amongst frontline workers. Especially towards young adults,

because the “moral obligation” to work and contribute to society by working is perceived as higher for young adults than for older adults. Especially if the young adult has never participated in paid work (Nørup et al, 2014a, Baadsgaard et al, 2014; Møller & Stone, 2012).

In general, the results from the Danish case point to a strong disproportion between the expectations in the policy and amongst the frontline workers to the workability of the young adults and the actual medical condition of limitations of the group. The young adults with medical problems are expected to be much closer to employment and medically and socially better than they actually are. This indicates a mismatch between the solution lined up in the policy and the nature of the actual problem. Some findings indicate that young adults themselves also cling to the dream of (re)entering the labour market despite of the fact that the dream from a medical point of view appears very distant. It seems that not only is the work norm, by some scholars referred to as the good worker (Bothfeld & Betzelt, 2013; Taylor-Gooby, 2009; Dean, 2007), highly present in the way these young adults perceived themselves and their relationship to society, but the norm is also institutionalized in the policy as well as it is integrated in the way the frontline workers in the Danish jobcentres perceived the content of their job and goal they are supposed to fulfill (Nørup et al, 2014).

#### *Activity compensation – a soft version of workfare*

The Swedish study is a bottom-up study of activity compensation. The program is investigated as practice, thus the perspectives of young adults with personal experiences of the program and front line workers, i.e. case administrators at the Social Insurance Agency, are important. The core material consists of interviews with 17 young adults. All 17 interviewees all have an anxiety diagnosis and/or depression diagnosis in their medical certificate on file at a local branch of the national insurance agency. The study design highlights activity compensation from ”both sides of the desk”. When possible, the respective administrator(s) at the local Swedish Social Insurance Agency for each young adult interviewed has been included in the interview study, which consists of two rounds of interviews. As selection was based on the insured young adult identifying the responsible case administrator, a young adult’s inability to identify this person made it impossible to contact the administrator for an interview. Together with the interview study the empirical material consists of official documents prescribing activity compensation. These include United Nations’ documents, legislative texts and internal directives.

Financial security and social participation are overall goals in early retirement pension systems (OECD, 2003). This holds for the Swedish system but since the reform in 2003 the latter has gradually been emphasized in the studied program, i.e. activity compensation. With *activity* as a tool, the goal of *participation* should be reached. This was one of the arguments used when the reform was launched in 2003. With the right to participate in activities activation policy obviously was introduced of within the field social and economic protection for people with medical problems and to make it even clearer, the term “activity compensation” replaced the old “early retirement”.

Changing perspective and going deeper into the views of the young interviewees, the study concludes that being young and unable to work due to a medical cause means that your life-trajectory is deviant. When you are in your twenties you are expected to be in your prime and contribute to society by performing paid work. Nevertheless, for many of the interviewees being granted activity compensation expanded their feeling of autonomy. Compared to social assistance, which was the previous source of supply for many of them, activity compensation meant that they could plan their personal finances for at least a year. While activity compensation is granted for at least one year and up till three years, social assistance normally is granted per month. Another important difference between social assistance and activity compensation reported by the interviewees, is that they no longer had to give an account for the amount of money received. Living on social assistance required book-keeping and control of every single purchase, while living on activity compensation gave the freedom to dispose the income. Speaking with Bothfeld and Betzelt, entering activity compensation meant increased autonomy in at least one dimension, namely the social. The status attached to activity compensation is higher than the one attached to social assistance. Furthermore, in Western capitalist societies the possibility to freely dispose of (at least a small amount of) money is an important prerequisite for personal autonomy.

Taking the perspective from the other side of the desk into account, resistance to the workfare logic was found among the case managers in the study. Although many of the interviewed administrators gave voice to the political ambition that the goal in every single case should be “return to work”, some expressed that this goal was not realistic for everyone. For some of the young adults living on activity compensation improved life-quality was a more adequate goal. Even the workfare logic expressed in sanctions was challenged by front line workers. “People don’t get their ability to work back just because we cut their benefits”, as one interviewed expressed it. This posture held by front-line workers can be interpreted as individual centered (Lipsky 2010). Instead of applying the state

focused goal that everyone should be integrated on the labour market, some front-line workers aimed at other goals, such as improved life-quality in some cases.

To sum up, in the political rhetoric, social participation has been delimited to refer to one part of society; the labour market. The good-worker norm permeates the notion of social participation and participation in paid work is the only activity that counts. All the interviewed young adults dreamt of a future where they were earning their living on paid work. The job-dream can be interpreted as the expression of the good-worker norm, professed by persons who do not have the possibility to perform paid work. While the front lines workers, by experience, knew that the chance to get a job was little for those having received activity compensation, the young adults themselves assessed these chances as substantial. Unfortunately, the gap between at one hand the dreams and plans pronounced by the young adults and the political rhetoric stating that paid work is the goal in every single case and on the other hand the experience-based, realistic estimation by the frontline workers is huge. As some of the case administrators knew, wise by experience, only a small share of the group of young persons that are entitled activity compensation will earn their living on paid work in the future. As a result, most cases will end up as failures if participation in paid work is the only goal that counts for persons receiving activity compensation.

## Discussion

Initially in this paper we stated that activation policies are permeating social policy within the field of social and economic protection for adults who for medical reasons cannot work. We also stated that very little was known of the effects and consequences of this activation to work regime, especially when targeting people who for medical reasons are unable to work. Based on findings from two recently submitted dissertations (Hultqvist, 2014; Nørup, 2014) this paper sheds light on consequences of the activation policies targeting young adults with medical problems.

As our findings show the activation to work policies have some general and unfortunate consequences in Sweden as well as in Denmark. One of the central problems is that these kinds of policies by definition reduce activation and participation to a question of participation in paid work. The young adults we have studied *cannot* work because of their medical condition. They are therefore unable to fulfill the obligation to participate and be active nested in the workfare logic and represented in activation policy. This means that rather than strengthening the social position of these often vulnerable young adults, the programs risk contributing to a further exclusion of the group, because it strengthen a participatory norm these young adults cannot adapt to. Rather than

providing the fundament of the societal inclusion that originally is a central aim in social policies in both countries, the strong focus on work and employment as the only including activities end up excluding these young adults even further because only work matters in the equation, and these young adults are prevented from work because of their health.

The narrow employment focus risk changing the way the society in general and the frontline workers in particular perceive these young adults and the nature of their problems. Nevertheless, in the Swedish case the administrators at local social insurance office demonstrated resistance when questioning the emphasis on work and pointing to the fact that a cut benefit was no cure for work disability.

The strong focus on employment also risks altering the way these young adults perceive themselves. The stronger the pressure to be included in ordinary employment, the bigger the risk that young adults consider themselves as wrong, of less value or not contributing sufficiently to society because they do not participate in paid work. Defining activity and participation so narrowly increases the stigma to young adults who are unable to work and increases the perception of being stigmatized amongst the young adults. Moreover, making structural problems in the functioning of labour markets a matter of personal shortcomings is not an efficient way of tackling the issue of unemployment.

In light of the Danish activation policies targeting young adults with medical problems the findings are worrying. The workfare logic applies pressure on the young adults to fit in to a specific norm and life form, often referred to as the good worker norm (Hultqvist, 2014; Dean, 2009; Taylor-Gooby, 2007). This without consideration of the fact, that they *cannot* meet the requirements of this norm because of their medical problems. This reduces autonomy and thereby risks increasing the social exclusion of the group. One of the most important findings of the Danish study is that autonomy and the feeling of control and ability to govern one's own life is crucial in order to avoid social exclusion. People with low degree of autonomy have weaker social relations and participate much less in all sort of activities. Young adults with medical problems have in general a much lower degree of autonomy because of their medical condition than people without medical issues. Decreasing the autonomy even further by making the social, and financial support contingent of participation in work-promoting activities in order promote a good worker can therefore be expected to have negative consequences when it comes to social inclusion. In terms of autonomy, the Swedish case shows that for many young adults with longstanding disability, being granted

activity means an increased possibility to govern one's own life. This is due to the fact that many young adults diagnosed with anxiety and/or depression enter the activity compensation program from a life situation where their main source of income has consisted in social assistance. The exact opposite result is the case in Denmark. Here the resource activation benefit for young adults in most cases equals the minimum amount of social assistance given to young adults. The income of the young adults during resource activation is substantially lower compared to the disability pension.

The young adults we have studied have very limited ability to work. For some the limitations are chronic while the limitations of others have a more temporary character. None the less neither would be able to take up full time work immediately. These young adults as a group are particularly vulnerable to social exclusion. In general, they have a weaker social network (not least due to school failure) than young adults without medical problems. One of the main goals of the Danish resource activation as well as the Swedish activation compensation is to prevent or lessen the social exclusion of the group by integrating them on the labour market. This goal has served as the legitimization of the activation policies targeting this group in general. In both the Danish and the Swedish case it was also used as the argument to strongly reduce the possibility for the citizens to get granted disability pension. The logic here was clear. Young adults who for medical reasons had a longstanding work disability and who therefore lacked the possibility to earn their living on wage labour were not part of the society. The reform in 2013 was named "Being part of society" (*En del af fællesskabet*) (Regeringen, 2012) and aimed at making these individuals part of society, i.e. making them participate on the labour market. If these young adults were integrated on the labour market the problem of social exclusion would be minimized or even disappear. The argument also legitimized the de facto reduction of benefits that became the result when disability pension were subsidized by resource activation. In Sweden, three government representatives stated in a newspaper article in 2012 (Kristersson, Engström & Larsson, 2012) that there was a need for "more roads leading in to the society" asking for more opportunities for young adults with activity compensation to enter the labour market. For them, inclusion in society meant inclusion on the labour market.

This is however not unproblematic. In the Danish study no connection between the labour market exclusion and general social exclusion were found. Instead the relation between the two were found to be highly spurious since both the exclusion from the labour market and the more general social exclusion to a large degree were caused by medical problems and health related limitations. In fact

it seems that when specifically analyzing young adults with very severe medical problems participation in work and work promoting activities actually reduces the experience of autonomy and worsen the general social and medical situation. This conclusion is also found in another recent Danish study (Bengtsson et al, 2014) and it raises the question if the extensive pressure put on people with documented very little or even close none workability is really making any sense, when little positive effect hereof can be documented.

It seems that individuals cope with labour market exclusion in many different ways, and that the social and psychological functions such as social contact, time structure, the feeling of doing something meaningful etc. also can be achieved elsewhere, for instance through spare time activities, hobbies or through contact with family or friends. In a Nordic context loss of income is to some degree compensated by unemployment benefits, which is probably one of the reasons why neither income nor labour market exclusion have the expected negative effects. In this sense one can say that the Nordic welfare state is in fact working by preventing social exclusion in the case of unemployment, but it does not do so in the case of extensive medical problems. However, when reducing benefits drastically as it has been done in Denmark recently, this financial protection against social exclusion in the event of unemployment can be expected to change this conclusion to some extent. Especially when this reduction of benefits are targeting people who are unable to take up work and who already are vulnerable to social exclusion because of their health problems, the consequences could be extensive.

The worrying tendency caused by activation policies targeting who for medical reasons cannot work is more crystalized in the Danish case, because the resource activation has stronger work fare elements than the Swedish activation compensation. This is not to say that the tendency is not found in Sweden. More likely Sweden has not gone as far in implementing work fare elements in practice within the field. Considering the workfare element in the policies as a continuum from state-centered and duty-based to individual-centered and rights based the Danish workfare element in the studied program can be placed close to the first pole while the Swedish workfare element can be placed close to the last pole, see figure 1 below.



Figure 1: Illustration of the continuum from state-centered workfare to individual- centered workfare



Given the fact that activation policies have been introduced in within the field of social and economic protection for adults who for medical reasons cannot work in both Denmark and Sweden, how could the differences be explained? While the trend to ‘homogenize’ (see for example Bothfeldt Betzelt 2013, p. 262) means-tested schemes for various target groups in the field of social policy is present in Denmark, this is not the case in Sweden. Even though activity compensation is not part of the pension system any longer it still belongs to the social insurances and thus to the system targeting a group of people considered to be ‘worthy’ recipients of financial support. Another possible explanation to the differences presented in this paper is the posture held by the frontline workers. In Denmark they seem to have adopted to the workfare logic while in the Swedish case they show signs of resistance when for example pleading that ‘improved life quality’ sometimes is a more adequate goal than ‘return to work’. Hence, it appears that the some Swedish frontline workers remain focused on the goals related to the individual while the Danish frontline workers now en masse have adapted the state centered goals. In the Danish case this change in the frontline work can be understood as a transition from a traditional semi-professionalism and work ethic focusing on the interests of the client towards a more organizational professionalism and ethic focusing on fulfilling the organizational goals of the jobcentres and the goals in the state policy (Nørup et al, 2014; Baadsgaard et al, 2013; Baadsgaard et al 2012). This transition has not fully taken place among the Swedish frontline workers.

So, how could the trend represented in concepts labelled active ‘social policy’, ‘activation’, ‘work-first’ and ‘work-fare’ be interpreted in the light of the Nordic welfare model?

Although the concepts are not totally synonymous they all refer to changes in welfare state reforms that have transformed the relation between the individual and the state. Boiled down to its essence this transformation means that while the state used to be active and take a large responsibility in procuring the citizens with the capacity for work, i. e through training, the responsibility to be

employable now rest on the citizen. It is a shift in emphasis where the term *active* used to refer to actions taken by the state now refers to actions taken by the citizen. In brief, the state now activates instead of being active.

### Concluding remarks

The paper has addressed the consequences of activation to work targeting young adults with medical problems in Denmark and Sweden. This has in the paper been addressed from two different angles. Firstly the consequences for the general life situation of the adults such as their level of autonomy and their ability to take part in society have analyzed and discussed. Secondly also the impact of the activation to work policies on the relationship between the individual and the state has been subject to investigation and discussion.

The results show that despite some overall similarities there are important differences between the countries. Both countries have in general adapted the workfare logic, but the extent to which is actually implemented vary substantially when looking at activation to work policies targeting young adults with medical problems. In the Swedish case the workfare logic is clearly present in the overall intention of the policy but it is not to the same extent implemented in practice. In practice, the Swedish activation compensation consists of some workfare elements but of elements associated with more traditional social policy effort. Likewise the Swedish frontline workers have not fully adapted to the workfare logic but remain to a rather large degree focused on the individual goals of client.

This is not the case in Denmark. Here the workfare logic is to a large degree found in the overall policy intention as well as amongst the frontline workers implementing the policy in practice. The Danish Resource activation has a very strong employment focus and despite being a rehabilitating effort targeting people with medical problems it represents strong workfare element.

Not surprisingly the counterproductive consequences of the activation policies discussed in this paper are more extensive in the Danish case. This does not mean that there are no negative consequences found in the Swedish. The workfare policies targeting young adults with medical problems have negative consequences in both in countries. The main difference is that so far in Sweden a softer version of workfare is implemented and that the activation compensation in Sweden is not solely an activation to program but consist also of other more social policy oriented elements.

The results presented in this paper are primarily based on two recent studies from Denmark and Sweden. The studies both focus on the consequences of activation to policies targeting young adults with medical problems but they do so based on different empirical basis. The Danish study is statistical while the Swedish study is interview and document based. Though the results from the Danish study are supplemented with interview based results from another recent Danish interview and document based study (Nørup et al, 2014, Baadsgaard et al, 2014), this limits the possibilities to draw detailed comparisons of the results simply because the empirical material can't be directly compared. However what can be compared is the overall conclusion regarding the consequences of the policies. Despite the different empirical foundation both studies address the same overall topic and raise similar questions as well as similar point of critique of the workfare policy line and both studies observes similar problems and counterproductive consequences when activation to work policies are targeting young adults with medical problems.

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